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ABSTRACT

This presentation and training aid provides a brief overview and discussion of the nature and scope of youth suicide, what prevention programs try to do, a framework for a public health approach, guides to programs and more. This material can be used for both handouts and as overheads for use with presentations. (GCP)

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ED 478 357

Youth Suicide Prevention: Mental Health and Public Health Perspectives.

A Presentation & Training Aid.

Center for Mental Health in Schools
University of California at Los Angeles

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A Presentation & Training Aid . . .

Youth Suicide Prevention: Mental Health and Public Health Perspectives

Slides & Script

June, 2003

This document is a hard copy version of a resource that can be downloaded at no cost from the Center's website http://smhp.psych.ucla.edu The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA. Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563 (310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

Presentation & Training Aid

Youth Suicide Prevention: Mental Health and Public Perspectives

Slides & Script

Periodically, opportunities arise for providing a presentation or an inservice session at schools about mental health and psychosocial concerns, When such opportunities appear, it may be helpful to access one of more of our Center's *Presentation & Training Aids*or *Quick Training Aids.*

Each of these aids is designed as a brief resource that can be easily adapted or used as is. (They also are a form of quick self-tutorial and a stimulus for group discussion.)

Most encompass (a) some key talking points that provide a brief overview of the topic, (b) facts/facts sheets, and (c) tools and references to a sampling of other related information and resources

In compiling resource material, the Center tries to identify those that represent "best practice" standards, If you know of better material, please **let us know** *so that we can make improvements.*

This training aid was designed for free online access. It can be used online and/or downloaded at http://smhp.psych.ucla.edu – go to "Quick Find to Center Developed Responses" and scroll the drop down menu of topics to *Suicide Prevention*. In addition to this aid, you will find a wealth of other resources on this topic.

Presentation Script

Slide 1 Hi. The following presentation on *Youth Suicide Prevention: Mental Health and Public Health Perspectives* was prepared by the staff of the Center for Mental Health in Schools at UCLA.

This presentation is designed as a training aid that you can download and readily adapt for local use.

Slide 2 As can be seen in the presentation overview, seven topics are covered -- including discussion of the nature and scope of the problem, what prevention programs try to do, a framework for a public health approach, guides to programs, and more.

Slide 3 Topic I focuses on the nature and scope of the youth suicide problem in the U.S.

Slide 4 Here are some frequently cited statistics. Take a minute or two to read them.

& As the data indicate, among youngsters aged 15-24 in the U.S., suicide ranks as the third leading cause of death – just behind homicide.

Slide 5 And, of course, the figures don't include all those deaths that actually were suicides but were classified as a homicide or accident.

Persons under the age of 25 accounted for 15% of all suicides, with older adolescents more likely than younger ones to commit suicide.

Among persons aged 15-19 years, firearm-related suicides accounted for 62% of the suicide rate over the last couple of decades.

The risk for suicide is greatest among young white males; however, American Indian and Alaskan Native adolescents have the highest rates, and from 1980 through the 1990s, suicide rates increased most rapidly among young black males.

And, while youth suicide has plateaued in recent years, the problem remains at what are almost historically high levels.

Slide 6 The economic costs to society continue to be debated. There is no debate, however, that concern for suicide prevention is an indicator of a humane society.

That is, any society that doesn't seriously attend to suicide prevention has too limited a commitment to the well-being of young people and ultimately pays a significant price for this lack of concern.

Slide 7

Efforts to prevent youth suicide must confront the basic question: *Why is it that so many young people end their lives?*

The search for answers inevitably takes us into the realm of psychopathology and especially the arena of depression.

But we must not only go in that direction.

As we become sensitive to symptoms of depression, it is essential to differentiate common-place periods of unhappiness from the syndrome that indicates clinical depression.

We must also remember that not all who commit suicide are clinically depressed and that most persons who are unhappy or even depressed do not commit suicide.

Moreover, as the Surgeon General's report on suicide wisely stresses, various problems experienced by young people are *linked.* This is a matter that has been raised frequently over the years, and yet its implications are widely ignored.

For example, a pervasive factor linking youth problems is life dissatisfaction.

For any youngster and among any group of youngsters, dissatisfaction with current life circumstances arises from multiple factors and can significantly affect emotions, thoughts, and behavior. And, when large numbers are affected in a neighborhood or at a school, the problem is exacerbated. In such cases, the need is not just to address the mental health problems of specific individuals but to develop public health approaches.

This, of course, involves developing interventions for addressing environmental, community, and system deficits – including family and peer factors.

And, such interventions not only must reflect an appreciation of the overlapping nature of the many "risk" factors associated with youngsters' emotional, behavioral, and learning problems, they must also encompass a comprehensive understanding of the full range of protective buffers that help alleviate problems.

Slide 8

Moving on to topic II – let's look more specifically at what prevention programs try to do.

From a public health perspective, a logical first emphasis is on enhancing awareness and increasing information among young people and their families, those who work with young people, and the general public.

Also from a public health perspective, a primary focus for prevention is on factors in the *environment* that are major contributors to problems. Thus, any sound preventive approach to youth suicide, youth depression, and youth violence must encompass extensive efforts aimed at systemic changes – with particular concern for how well diversity is accommodated.

For example, many aspects of schools and schooling have been identified as possible contributors to youngsters' alienation and sense of despair. Clearly, such school-related factors should be major targets for change. Of particular concern are changes that can enhance a caring and supportive climate and reduce unnecessary stress throughout a school. Such changes not only can have positive impact on current problems, they can prevent subsequent ones.

At the same time, efforts must focus on *appropriately* identifying those at risk and building the capacity of schools, families, and communities to help.

Note that the emphasis is on *appropriate* identification. This is because of concerns that have arisen about large scale screening, as well as concerns about the lack of availability of programs to help when referrals are made.

Concerns about large scale screening are discussed later in this presentation.

With respect to the problem of program availability, it is essential to remember that many youth problems are linked.

With this in mind, it is important to avoid thinking too narrowly about youth suicide prevention. Most programs for high-risk youth are concerned about many of the same risk factors and protective buffers. Thus, treatment programs for alcohol and drug abuse and programs that provide help and services to runaways, pregnant teens, or school dropouts all address factors relevant to preventing suicide.

We can all enhance program availability for a variety of problems by reversing the trend that creates so many separate categorical programs. By ending unneeded specialization, resources can be redeployed and steps taken to establish comprehensive, multifaceted, and cohesive approaches.

Finally, concern about countering tendencies to overemphasize individual pathology and personal deficits has led to greater appreciation of the importance of designing approaches in ways that foster resilience and protective buffers. As a result, a strong movement has emerged for enhancing youngsters' assets related to social and emotional problem solving. This includes teaching stress management, coping skills, compensatory strategies, and so forth.

Slide 9 Moving on to topic III – let's look at a framework for a public health approach.

Slide 10 When one puts suicide prevention into a public health perspective, it is essential to use a comprehensive, multifaceted, and cohesive framework that highlights the interconnected systems necessary for meeting the complex needs of all youth.

As the figure illustrates, the desired interventions can be conceived along a continuum spanning primary, secondary, and tertiary prevention – including universal, selective, and indicated interventions.

Slide 11 Such a continuum must be woven into three overlapping systems: a system for positive development and prevention of problems (which includes a focus on wellness or competence enhancement), a system of early intervention to address problems as soon after their onset as feasible, and a system of care for those with chronic and severe problems.

Slide 12 The continuum incorporates a holistic and developmental emphasis that encompasses individuals, families, and the contexts in which they live, work, and play.

It also provides a framework for adhering to the principle that we should use the least restrictive and nonintrusive forms of intervention needed to appropriately respond to problems and accommodate diversity.

Moreover, given the likelihood that many problems are not discrete, the continuum can be designed to address root causes, thereby minimizing tendencies to develop separate programs for each observed problem.

Slide 13 Most importantly, full development of the overlapping systems is essential to stemming the tide of referrals for specialized assistance. Currently, the only one of these systems that is even marginally in place is the system of care. This has resulted in what has been described as a waiting for failure approach. Until the other systems are well-developed, we will continue to inappropriately flood deep-end services and make it virtually impossible for them to do their work effectively.

Slide 14 Ultimately, the framework enhances mapping and analyzing community and school resources with a view to increasing coordination and integration, enhancing the way the interventions are connected, and evaluating impact and cost-effectiveness. In turn, this provides a solid basis for redeploying and braiding resources to fill gaps and strengthen existing interventions.

Of course, developing such a systemic framework requires extensive community and school collaboration to braid resources and build capacity to enhance policy, refine infrastructure, and expand training for leadership personnel and for a wide-range of primary care providers.

All this is essential to increasing the availability of programs for youth and evolving them into an effective continuum of integrated *systems*.

Slide 15 Topic IV brings us to a set of resources that are designed to guide decision makers to model programs.

Slide 16 Decision makers need ready access to information on how to approach suicide prevention. Each of the documents cited are major works from well-respected sources. They contain discussions ranging from national strategies to model programs and best practices for addressing risks and promoting healthy development. They provide basic references and links to resources.

Included on the list are the *National Strategy for Suicide Prevention* from the Surgeon General's office and a major review of the field from the National Academy of Science's Institute of Medicine.

Also cited is CDC's 1992 guide to youth suicide programs and a major review published in 2003 in a peer-reviewed journal.

Slide 17 Finally, two resources to overviews of social and emotional and youth development programs are listed.

All but the journal article can be readily accessed on the internet.

Slide 18 Topic V brings us to matter of what role schools can play.

Slide 19 First of all, it is important to make the case for why schools should play a role. There are several major reasons:

One is that schools cannot achieve their mission of educating the young when students' problems are major barriers to learning and development. As the Carnegie Task Force on Education has stated: *School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.*

A second reason schools should play a role is that they are at times a source of the problem and need to take steps to minimize factors that lead to student alienation and despair.

Schools also are in a unique position to promote healthy development and protective buffers, offer risk prevention programs, and help to identify and guide students in need of special assistance.

Slide 20 With respect to such identification, there are a variety of checklists designed to help school staff and parents when they have reason to fear that a youngster is suicidal. Checklists help to highlight key points.

For example, the Suicidal Assessment Checklist on the screen outlines matters that might be covered with a student and/or parent. As you can see, it covers concerns about the youngster's past attempts, current plans, view of death, reactions to precipitating events, history of risk taking behavior, and available psychosocial supports. Take a minute to read over the specific questions related to each area.

Slide 21 Now look at the next checklist which covers follow-through steps. Outlined are concerns ranging from assisting the youngster, contacting and follow-up with parents, and reporting child endangerment if necessary.

As you can see, the points on these checklists have relevance for anyone who is confronted with a youngster who may be suicidal.

Other checklists outline procedures for schools to follow in the aftermath of a youth suicide and are available in resource aids developed by our Center.

Slide 22 At this point a few cautions are in order.

Clearly, any indicators of unhappiness are reasons for concern. However, even well trained professionals using the best available assessment procedures find it challenging to determine whether an individual is suicidal. The dilemma is to attend to potential problems without over-reacting.

This dilemma is exacerbated when large-scale screening programs are put into practice. The type of first level screens that are often advocated tend to produce too many false positives. This leads to over-referrals and results in an unfortunate misuse of scarce resources.

Another concern arises when school suicide prevention efforts involve students in looking for and reporting problems among their peers. While the intent may be to foster a climate of social support and caring, too often what is created is an atmosphere of surveillance and overreaction. When this happens, the strategy can run counter to efforts designed to promote empathy and a sense of community.

Slide 23

We hope this presentation has provided you with a useful beginning overview to the topic of youth suicide prevention. You are free to download and use it as a training aid in your work. It can be accessed either from the maternal and child com archives or our Center's website.

For ready access to more on this topic, the general resources displayed on your screen can be accessed. These include SAMHSA's National Mental Health Info Center, CDC's information resources, and the Bright Futures resources developed with support from HRSA.

Slide 24

And, of course, our Center and our sister Center at the University of Maryland provide a range of training and technical assistance resources.

Slide 25

Our Center also has developed a set of specific aids on this topic. Each of the resources listed on the screen can be downloaded from our website.

In addition, many documents and links can be accessed through our Center website's Quick Find menu.

By way of conclusion, the following points are worth underscoring.

It is essential to approach youth suicide from both a mental health and public health perspective.

A logical first emphasis is on enhancing awareness and increasing information among young people and their families, those who work with young people, and the general public.

A primary focus for prevention is on factors in the *environment* that are major contributors to problems.

Efforts also must focus on *appropriately* identifying those at risk and building the capacity of schools, families, and communities to help.

It is essential to embed prevention programs into a comprehensive, multifaceted, and cohesive framework designed as interconnected systems for meeting the complex needs of all youth.

Finally, we stress that schools have an important role to play in suicide prevention and are in a unique position to promote healthy development and protective buffers, offer risk prevention programs, and help to identify and guide students in need of special assistance.

As we all know, promoting healthy development and addressing barriers to youth well-being requires the best efforts of families, schools, and communities working together in the best interest of all children.

We wish you well in your work, and thank you for taking the time today to enhance your understanding of youth suicide prevention. We hope that you will feel free to contact our Center as you identify needs for technical assistance and training related to concerns about mental health in schools.

UCLA

Youth Suicide Prevention: Mental Health and Public Health Perspectives

(A Presentation and a Training Aid)

Prepared by the staff of the Center for Mental Health in Schools at UCLA

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA. Write: Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563. Phone: (310) 825-3634 Fax: (310) 206-8716

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Presentation Overview

I. Youth suicide in the U.S. – How big is the problem?

II. What do prevention programs try to do?

III. Framework for a public health approach

IV. Guiding decision makers to model programs

V. The key role schools can play

VI. A few cautions

VII. Finding other training aids

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I. Youth suicide in the U.S. – How big is the problem?

Suicide in the United States - The Problem

- More people die from suicide than from homicide.
- Overall, suicide is the eighth leading cause of death for all Americans, and is the third leading cause of death for young people aged 15-24.
- Males are four times more likely to die from suicide than are females. However, females are more likely to attempt suicide than are males.
- White males and white females accounted for over 90% of all suicides.
- Suicide rates are generally higher than the national average in the western states and lower in the eastern and midwestern states.
- Nearly 3 of every 5 suicides (58%) were committed with a firearm.

Sources: *National Center for Injury Prevention & Control*
http://www.cdc.gov/ncipc/factsheets/suifacts.htm

National Center for Health Statistics – Wonder Database
http://www.cdc.gov/mortICD9J.shtml

Suicide Among the Young

- Persons under age 25 accounted for 15% of all suicides; older adolescents are more likely than younger ones to commit suicide.
- For young people 15-24 years old, suicide is the third leading cause of death, behind unintentional injury and homicide.
- Among persons aged 15-19 years, firearm-related suicides accounted for 62% of the overall increasing suicide rate from 1980 through the 1990s.
- The risk for suicide is greatest among young white males; however, from 1980 through the 1990s, suicide rates increased most rapidly among young black males; American Indian and Alaskan Native adolescents have the highest *rates.*
- Although suicide among the young is relatively rare and rates have plateaued for adolescents as a whole, the problem remains a dramatic one and intensified efforts are needed to prevent suicide among young people.

Sources: *National Center for Injury Prevention & Control*
http://www.cdc.gov/ncipc/factsheets/suifacts.htm

National Center for Health Statistics – Wonder Database
http://www.cdc.gov/mortICD9J.shtml

Suicide: Cost to the Nation

- One group of researchers states: "In economic and human terms, youth suicide in the United States is a public health problem of the first magnitude." Based on data available in 1980, they estimate that the cost to society was $2.27 billion.[1]

- In contrast, others suggest that such figures are overestimates because youth suicide often results in net economic savings by cutting short the need for treatment and other social benefits for those who are seriously disturbed and marginal society members.[2]

- Beyond the economic debate, most agree that concern for suicide prevention is an indicator of a humane society. And, any society that fails to attend to youth suicide prevention has too limited a commitment to the well-being of young people and will pay a price for this lack of concern.

[1]Weinstein, M.C., & Saturno, P.J. (1989).Economic impact of youth suicides and suicide attempts. In *Report of the secretary's task force on youth suicide.* (Vol. 4, pp. 82-93). Washington, DC: GPO.
[2]Lester, D., & Yang, B. (2001). *The economic cost of suicide.* As reported in D. Lester (2003), Adolescent suicide from an international perspective. *American Behavioral Scientist, 46,* 1157-1170

Why would a young person attempt suicide?

- Too many are unhappy – for different reasons
  - >environmental/community/system deficits (e.g., impoverished neighborhoods & schools)
  - >family factors (e.g., economic reversals, conflict)
  - >peer factors (e.g., rejection, alienation)
  - >psycho-biological factors (e.g., predisposition)
- Need to be careful not to overpathologize*

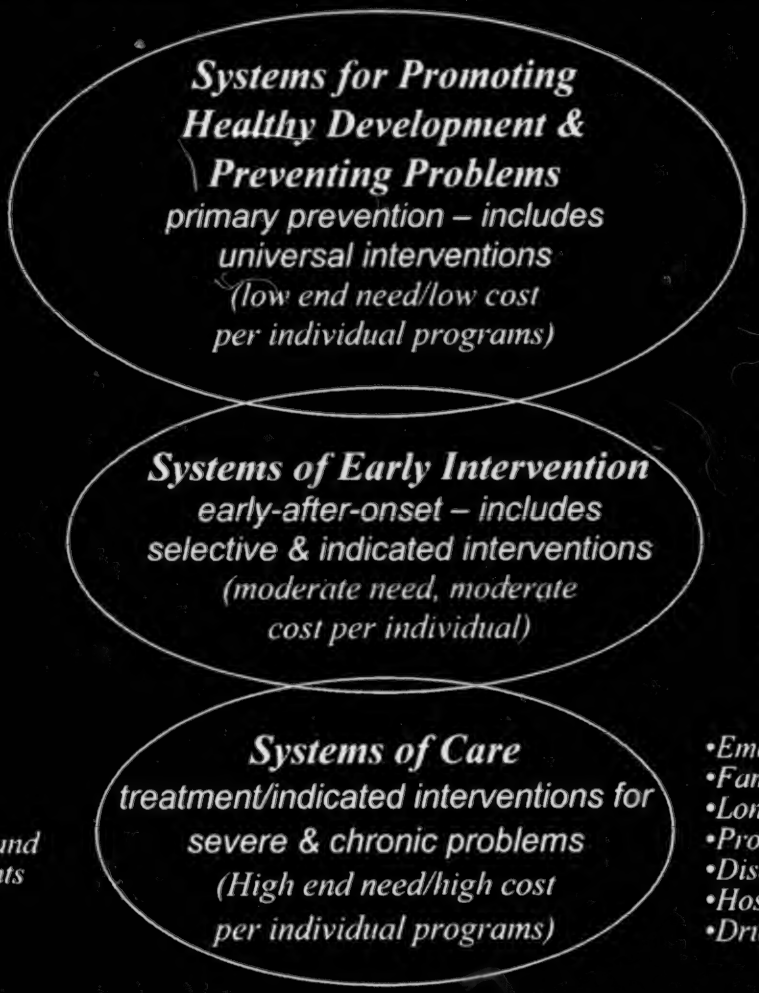
*See *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (DSM-PC) – developed by the American Academy of Pediatrics for a useful resource to help counter tendencies to overpathologize.

II. What do prevention programs try to do?

- Enhance awareness and increase information among students, staff, family, and community
- Change environments and systems – with particular concern for diversity
- Enhance identification of those at risk and build capacity of school, family, & community to help
- Enhance competence/assets related to social and emotional problem solving (e.g., stress management, coping skills, compensatory strategies)
- Enhance Protective Buffers

III. Framework for a public health approach

Interconnected Systems for Meeting the Needs of All Youth



Systemic collaboration is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among systems of prevention, systems of early intervention, and systems of care.

(Developed by H. S. Adelman and L. Taylor and circulated through the Center for Mental Health in Schools at UCLA.)

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The figure illustrates a continuum spanning primary, secondary, and tertiary prevention – including universal, selective, and indicated interventions.

The interventions must be woven into three overlapping systems:

- a system for positive development and prevention of problems (which includes a focus on wellness or competence enhancement)
- a system of early intervention to address problems as soon after their onset as feasible
- a system of care for those with chronic and severe problems.

The continuum incorporates a holistic and developmental emphasis that encompasses individuals, families, and the contexts in which they live, work, and play.

It also provides a framework for adhering to the principle that we should use the least restrictive and nonintrusive forms of intervention needed to appropriately respond to problems and accommodate diversity.

Most importantly, full development of the overlapping systems is essential to stemming the tide of referrals for specialized assistance.

Currently, the only one of these systems that is even marginally in place is the system of care.

This has resulted in what has been described as a ***waiting for failure*** approach.

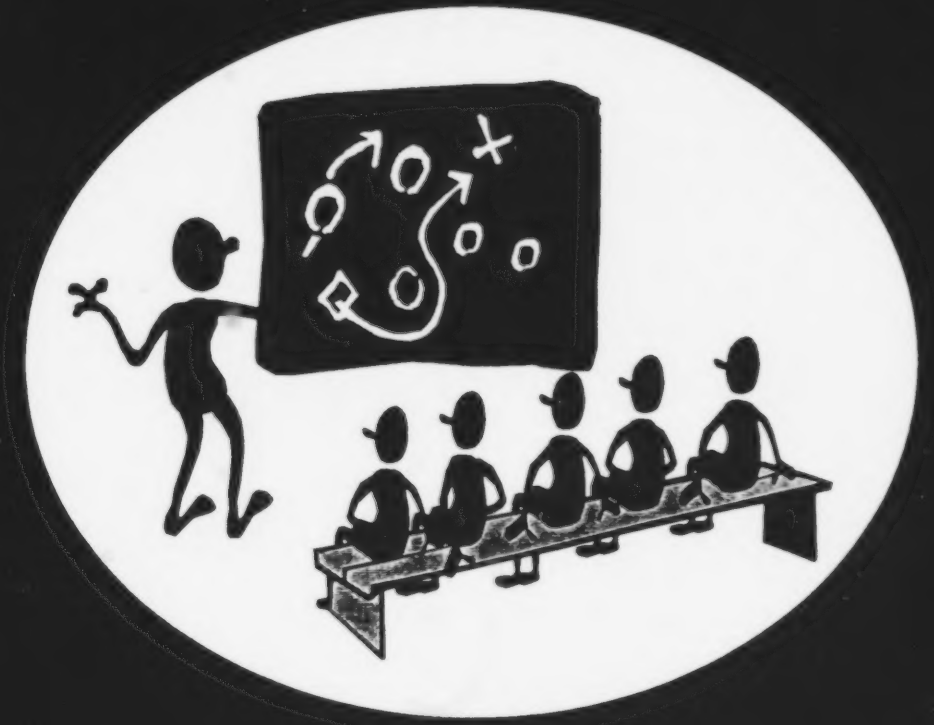
Until the other systems are well-developed, we will continue to inappropriately flood deep-end services and make it virtually impossible for them to do their work effectively.

Braiding Resources and Building Capacity

Development of a full continuum involves community and school collaboration.

- Policy
  (e.g., supporting development of the full continuum)
- Infrastructure
  (e.g., collaborative mechanisms)
- Training
  (e.g., leaders, primary care providers)

IV. Guiding decision makers to model programs



»*National Strategy for Suicide Prevention* (2001).
http://www.mentalhealth.org/suicideprevention

»*Reducing Suicide: A National Imperative* (2002). Institute of Medicine (National Academy Press). See Chapter 8 for reviews of "Programs for Suicide Prevention."
http://www.nap.edu/books/0309083214/html/273.html

»*Youth Suicide Prevention Programs: A Resource Guide* (1992) – CDC
http://www.cdc.gov/ncipc/dvp/Chapter%201.PDF

»*School Interventions to Prevent Youth Suicide.* A Technical Aid Sampler (Center for Mental Health in Schools at UCLA)
http://smhp.psych.ucla.edu

»Kalafat, J. (2003) School approaches to youth suicide prevention. *American Behavioral Scientist, 46,* 1211-1223.

Promoting Healthy Social-Emotional Development

» *Safe and Sound. An Educational Leader's Guide to Evidence-Based Social & Emotional Learning Programs* (2002). The Collaborative for Academic, Social, and Emotional Learning (CASEL).

http://www.casel.org

» *Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs (2002).* Social Develop. Res. Group, Univ. of Wash.

See Online journal *Prevention & Treatment*
http://journals.apa.org/prevention/volume5/pre0050015a.html

V. The key role schools can play

Why should schools play a role?

- Schools cannot achieve their mission of educating the young when students' problems are major barriers to learning and development. As the Carnegie Task Force on Education has stated: ***School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.***
- Schools are at times a source of the problem and need to take steps to minimize factors that lead to student alienation and despair.
- Schools also are in a unique position to promote healthy development and protective buffers, offer risk prevention programs, and help to identify and guide students in need of special assistance.

Suicidal Assessment - checklist

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

- ✓*Does the individual have frequent suicidal thoughts?*
- ✓*Have there been suicide attempts by the student or significant others in his or her life?*
- ✓*Does the student have a detailed, feasible plan?*
- ✓*Has s/he made special arrangements as giving away prized possessions?*
- ✓*Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife?*

(2) REACTIONS TO PRECIPITATING EVENTS

- ✓*Is the student experiencing severe psychological distress?*
- ✓*Have there been major changes in recent behavior along with negative feelings and thoughts?*

(3) PSYCHOSOCIAL SUPPORT

- ✓*Is there a lack of a significant other to help the student survive?*
- ✓*Does the student feel alienated?*

(4) HISTORY OF RISK-TAKING BEHAVIOR

- ✓*Does the student take life-threatening risks or display poor impulse control?*

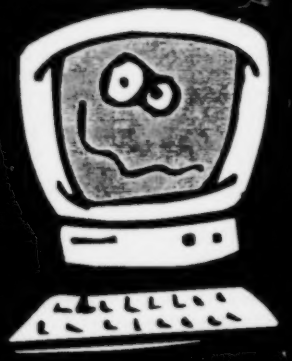
Follow-through steps after assessing suicidal risk

- Avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.
- Explain the importance of and your responsibility for breaking confidentiality in the case of suicidal risk.
- Be certain the student is in a supportive and understanding environment.
- Try to contact parents by phone.
- If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help.
- Follow-up with student and parents to determine what steps have been taken to minimize risk.
- Document all steps taken and outcomes. Plan for aftermath intervention and support.
- Report child endangerment if necessary.

VI. A few cautions

- Even well trained professionals using the best available assessment procedures find it challenging to determine whether an individual is suicidal.
- **Large-scale *screening*** usually generates too many false positives and thus leads to over-referral and inappropriate consumption of scarce resources
- Involvement of students in looking for and reporting problems can run counter to efforts designed to promote empathy, caring, social support, and a sense of community.

VII. Finding other training aids



Go to:

- *National Mental Health Information Center*
  http://www.mentalhealth.org/cmhs/default.asp
- *Centers for Disease Control and Prevention*
  http://cdc.gov/ncipc/factsheets/suifacts.htm
- *Bright Futures in Practice: Mental Health*
  www.brightfutures.org

And, of course, the two national centers focused on mental health in schools:

- *Center for Mental Health in Schools* at UCLA

  http://smhp.psych.ucla.edu

- *Center for School Mental Health Assistance* at the University of Maryland, Baltimore

  http://csmha.umaryland.edu/

Some Specific Aids to Download from our Website

http://smhp.psych.ucla.edu

» *Suicide Prevention*
(a "Quick Training Aid")

» *School Interventions to Prevent Youth Suicide.*
(a "Technical Aid Sampler")

» *Youth Suicide/Depression/Violence*
(article in the Center's quarterly newsletter)

» *Suicide Prevention*
("Quick Find" topic containing all the above along with references and links to other relevant resources)

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